IN THE

Supreme Court of the United States

October Term, 1975

No. 75-1690

T.M. "JIM" PARHAM, Individually and as Commissioner of the Department of Human Resources, W. DOUGLAS SKELTON, Individually and as Director of the Division of Mental Health and W.T. SMITH, Individually and as Chief Medical Officer of Central State Hospital,

Appellants,

v.

J.L. AND J.R., Minors, Individually and as representatives of a class of persons similarly situated,

Appellees.

APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA

BRIEF FOR APPELLANTS

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OPINION BELOW

The opinion of the district court is reported at 412 F. Supp. 112. A copy of the opinion is set forth in Appendix A to the Jurisdictional Statement.

JURISDICTION

The decision of the district court was entered February 26, 1976, with final judgment entered thereon on March 11, 1976. A notice of appeal was filed on March 24, 1976 and this Court noted probable jurisdiction on May 31, 1977.

The jurisdiction of this Court is conferred by Title 28, United States Code, Section 1253.

QUESTIONS PRESENTED

I. Whether the Due Process Clause of the Fourteenth Amendment requires parents, or persons standing in their stead, to secure approval, in an adversarial proceeding against their child, prior to securing for that child medically-indicated institutional mental health services afforded by the State?

II. Whether, when the parents of a minor voluntarily place the minor in a State mental health facility, there is sufficient "state action," including subsequent action by the State mental health facility, to implicate the Due Process Clause of the Fourteenth Amendment?

III. Whether, assuming that more than one treatment setting would benefit a mentally ill person under 18 years of age, the Fourteenth Amendment to the Constitution of the United States mandates that the State must, if it is to provide services at all, provide needed mental health services in the most appropriate treatment setting commensurate with the minor's condition?

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

UNITED STATES CONSTITUTION

Section I, Fourteenth Amendment to the Constitution:

> SECTION 1. All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

GEORGIA STATUTES

Ga. Code §88-503.1:

> 88-503.1. Authority to receive voluntary patients. —(a) The superintendent of any facility may receive for observation and diagnosis any individual 18 years of age, or older, making application therefor, any individual under 18 years of age for whom such application is made by his parent or guardian and any person legally adjudged to be incompetent for whom such application is made by his guardian. If found to show evidence of mental illness and to be suitable for treatment, such person may be given care and treatment at such facility and such person may be detained by such facility for such period and under such conditions as may be authorized by law.
>
> (b) The superintendent of any evaluating facility may receive for observation and diagnosis any individual 14 years of age or older who makes application therefor. If such individual is under 18 years of age, his parent or guardian may apply for his discharge and the superintendent shall release the patient within five days of such application for discharge.

STATEMENT OF THE CASE

In 1969 Georgia adopted a comprehensive and substantially modernized mental health code, codified as Ga. Code Ch. 88-5 (Ga. Laws 1969, p. 505). One major thrust of this Code was to insure that any person who was in need of mental health services and who wished voluntarily to seek State-provided treatment could do so. Recognizing that minors are incapable, because of their lack of maturity, of making such an informed consent as would enable them to receive mental health treatment, the General Assembly of Georgia provided that the parents or guardian of a person under eighteen years of age could act for their child in seeking voluntary treatment for their child's mental illness[1].

Both Appellees were admitted to a State mental health facility in 1970, upon the application of their parents or guardian as provided in Ga. Code § 88-503.1(a). The diagnosis given to J.L. was "hyperkinetic reaction of childhood" (A. 78). J.R. was diagnosed as having "borderline mental retardation" and an "unsocialized, aggressive reaction of childhood" (A. 122)[2].

Since both Appellees were admitted to the State mental health facility pursuant to the provisions of Ga. Code § 88-503.1(a), there were no hearings held where, with the assistance of counsel, they could challenge either the basis of their parents' or guardian's decision to seek psychiatric inpatient therapy for them, or the medical findings and recommendations with respect to the necessity for such treatment.

After their admission to the hospital, both Appellees

[1] *See* Ga. Code § 88-503.1(a).

[2] The summary description of each child's mental illness is taken from the Diagnostic and Statistical Manual of Mental Disorders II (DSM-II), 3rd Edition, published by the American Psychiatric Association.

remained in the State mental health facility, with brief exceptions, until this lawsuit was filed. J.L. was discharged for approximately ten days in 1972, but was readmitted to the hospital upon the application of his adoptive mother and step-father (A. 69). J.R., who had been placed in five foster homes prior to his admission to the hospital, was placed in foster homes on four separate occasions after his original admission to the hospital, but in each case the placement ended with his being returned to the hospital (A. 71-72).

On October 24, 1975, this lawsuit was filed on behalf of the two Appellees, against T.M. "Jim" Parham, the Commissioner of the Georgia Department of Human Resources, W. Douglas Skelton, M.D., the Director of the Mental Health Division of the Department of Human Resources, and W.T. Smith, Chief Medical Officer of Central State Hospital, the Appellants, seeking to enjoin the utilization of that provision of Ga. Code § 88-503.1(a), which recognizes that parents and guardians may make application for admission to a mental health facility for their children under eighteen years of age, and allows State facilities to provide such requested mental health services upon the concurrence of the superintendent of the facility that such services are suitable (A. 1).

The challenge to Ga. Code § 88-503.1(a) was predicated first upon the contention that Appellees were not voluntary patients, but were involuntarily committed to and incarcerated in a State mental health facility without having been afforded a meaningful and complete opportunity to be heard and, consequently, that they had been deprived of their liberty without procedural due process of law.

Second, it was alleged that through the operation of the challenged statute Appellees were placed directly in a mental health facility without any initial or periodic

consideration of placement in a less-restrictive environment[3], and that therefore they had again been denied their liberty without due process of law in violation of the Fourteenth Amendment to the Constitution of the United States.

Shortly after the suit was filed, on November 19, 1975, a three-judge district court was convened and a hearing was held to consider the claims made by the Appellees. After hearing oral argument on the legal issues presented by the complaint, the court directed that the matter be submitted by stipulation and upon testimony taken by deposition.

The Appellants' position at the hearing, and at all other times pertinent hereto, was that the decision to seek hospitalization for a child is one properly made by parents or guardians, who traditionally have been charged with the power and the duty to provide for the maintenance, protection and education of their children. The Appellants argued that children's protection, if any were required, lay in the fact that the parents or guardians could make application for admission to the State mental health facility, but that children could not be admitted unless the superintendent of the facility found that the children showed signs of mental illness and were suitable for treatment in that facility.

The evidence adduced before the district court related primarily to the operation of Ga. Code § 88-503.1(a) and the value of alternatives to that statute suggested by Appellees.

The evidence demonstrated that the Georgia mental health facilities had policies and practices which resulted,

[3] At the time of the filing of this lawsuit the hospital staff was of the opinion that both J.L. and J.R. could be treated for their mental illnesses in a different treatment setting. (A. 109, 156).

prior to the admission of a mentally ill child to the facility, in the consideration of alternative placements for the child (A. 250, 280, 355, 443, 479, 522). The evidence further showed that the facilities conducted a careful screening before admission to insure that the child in fact was mentally ill and suitable for treatment in that particular facility (A. 270, 322, 384, 465, 513 *et seq.*, 548, 588).

With respect to the issue of the periodic review of each child, and the appropriateness of the treatment setting, the evidence indicated that fifty percent of all children admitted under the challenged Code section were released within sixty days of their admission and that eighty percent were discharged within six months (A. 822 *et. seq.*).

There was no substantial evidence introduced which demonstrated that any restrictions were imposed upon any child because of his placement in a State mental health facility, as opposed to any other treatment setting, a significant consideration in light of the subsequent district court order concerning the forty-six children for whom hospitalization was not considered the "most appropriate" treatment setting[4].

Finally, the evidence below demonstrated that the Department of Human Resources, the agency charged with the administration of State-provided mental health services, did not and would not have sufficient funds to provide a full range of "most appropriate" treatment settings for those children presently in its custody, much less for all those who might, in the future, be committed to its custody.

On February 26, 1976, the three-judge district court entered an order holding that the challenged statute and

[4] Opinion of the District Court, Juris. St. 54a.

the practices of the Appellants were unconstitutional. The district court did three things. First, it permanently enjoined and restrained the Appellants from "further detaining or confining" any child under eighteen years of age in any mental health facility of the State of Georgia pursuant to a voluntary admission by a parent or guardian under the challenged provisions of Ga. Code § 88-503.1(a). Second, the court ordered, with respect to those children who were then in State mental health facilities, that the Appellants either (1) commence proceedings within sixty days under some law not found to be unconstitutional to obtain proper legal authority to detain the Appellees or (2) make necessary arrangements to completely remove the Appellees from the custody of the Appellants or any other official or agency of the State of Georgia. Third, the court ordered that, with respect to those children for whom a hospital was not the "most appropriate" treatment setting, Appellants provide the necessary physical resources and personnel for whatever non-hospital facilities were deemed to be most appropriate for those children.

On March 11, 1976, the three-judge district court entered a judgment based on the opinion and order entered February 26, 1976, incorporating its conclusions and directions as set forth above. It is from this order and judgment that this appeal is taken.

SUMMARY OF ARGUMENT

This case presents novel and difficult questions concerning the relationship of parents and their children. The central issue is whether parents may, with the advice of a physician, determine that their children will receive treatment for mental illness in a State mental health facility.

The district court ruled that parents may not make this decision for their children, even with the concurrence of a physician, but rather that the children are entitled to have the issue of their need for hospitalization resolved in an adversarial proceeding. By so holding, the decision of the district court narrows the scope of parents' responsibilities to, and authority over, their children in a fashion which is inconsistent with this Court's prior decisions. *See Wisconsin v. Yoder*, 406 U.S. 205 (1972). Furthermore, the holding of the district court, which is predicated on the finding that psychiatrists and psychiatry are unreliable, fails to give the deference to the medical opinions of physicians required by this Court's decision in *Doe v. Bolton*, 410 U.S. 179 (1973), and is contrary to the evidence in the record which demonstrates that diagnoses by psychiatrists are no less reliable than diagnoses of a number of physical disorders.

It is the Appellants' position that parents may, with the concurrence of a physician, constitutionally make a medically-indicated decision for their minor children, without being hindered by the State. However, Appellants submit that the present case does not provide the proper vehicle for determining that proposition since there is no "state action" involved. The challenged statute, Ga. Code § 88-503.1(a) does not give parents the authority to confine their children; nor does the statute encourage

parents to hospitalize their children. Both the decision to admit the children, and the decision that they are to remain in the mental health facility, belong solely to the parents or guardians as long as the children are mentally ill and suitable for treatment. The State is merely fulfilling a proprietary function similar to that of a private hospital, and it is fundamentally unfair to require that parents be subjected to adversarial hearings and confrontations with their mentally ill children simply because the parents happen to select a State mental health facility for their children, rather than costly private facilities.

Even if the district court is correct in determining that mentally ill children are entitled to some due process prior to hospitalization, the court erred in its determination of "what process is due." This Court in *Mathews v. Eldridge*, 424 U.S. 319 (1976), *Ingraham v. Wright*, ___ U.S. ___, 97 S.Ct. 1401 (1977), and *Smith v. Organization of Foster Families for Equality and Reform*, ___ U.S. ___, 97 S.Ct. 2094 (1977), held that three factors must be considered in any determination of what due process is required in a particular situation: 1) the private interest that will be affected; 2) the risk of an erroneous deprivation of such interest and the probable value, if any, of additional or substitute procedures; and 3) the burden upon the State in providing such additional procedures.

An application of these criteria to the present facts indicates that the procedural rights of children cannot be expanded except at the expense of parents' responsibility and authority, previously recognized by this Court, to decide the direction of their children's upbringing. Moreover, from a practical viewpoint, the evidence indicated that under present procedures children generally are not admitted to State mental health facilities until they have

been seen at a community mental health center, and until alternative placements have been considered. Additionally, children are carefully screened to insure their suitability for hospitalization, not only by the admitting psychiatrist, but also by psychologists, social workers and other mental health professionals.

Not only did the evidence demonstrate that children are sufficiently protected by the present procedures, but most of the persons testifying felt that any additional procedures would merely add unwarranted impediments to the hospitalization of children and that such impediments, in the form of adversarial hearings, would frequently prove harmful to mentally ill children.

In addition to ruling that children are entitled to due process hearings before they can be admitted to State mental health facilities, the district court also determined that the children may be hospitalized only if that is the "most appropriate" treatment setting. In reaching this decision the district court relied upon the "less drastic means" doctrine. However, the application of this constitutional doctrine to the present case is entirely inappropriate, not only because the children are voluntary patients, but also because the "less drastic means" doctrine wrongly presupposes that children possess the same right to liberty as adults, a conclusion which is unsupportable in fact or law.

The district court's decision requires additional procedures where none are needed; it creates situations where children will be denied treatment for their mental illness because the "most appropriate" treatment setting is not available. Neither result is constitutionally mandated, and both portend serious consequences to the very children sought to be protected. The district court's decision should be reversed.

ARGUMENT

I. WHEN A PARENT OR GUARDIAN, ACTING WITH THE CONCURRENCE OF A PHYSICIAN, DETERMINES THAT A MINOR CHILD IS MENTALLY ILL AND IN NEED OF TREATMENT, THE CONSTITUTION DOES NOT MANDATE THAT THERE BE A PROCEDURE THROUGH WHICH THE PARENT'S OR GUARDIAN'S DECISION MAY BE CHALLENGED BY THE CHILD IN AN ADVERSARIAL PROCEEDING.

The special relationship between parents and their children has been recognized throughout recorded history. It is almost universally accepted, both in our society and in others, that parents and guardians have a duty to maintain their children during their infancy, and to make reasonable provision for their children's happiness and well-being[5]. The rationale which supports the relationship, and the relative position of the parents with respect to their children, was well stated by Blackstone in his Commentaries, where he noted:

> "The duty of parents to provide for the *maintenance* of their children, is a principle of natural law; an obligation, . . . laid on them not only by nature herself, but by their own proper act, in bringing them into the world: for they would be in the highest manner injurious to their issue, if they only gave their children life that they might afterwards see them perish. By begetting them, therefore, they have entered into a voluntary obligation to endeavor, as far as in them lies, that the life which they have bestowed shall be supported and preserved. And thus the children will have the perfect *right* of receiving maintenance from the parents." 1 Blackstone, Commentaries, *447. [Emphasis in original].

[5] 1 Children and Youth in America, A Documentary History 363 (R. P. Bremner ed. 1970).

This concept is not merely of historical interest for, as this Court, in *Wisconsin v. Yoder*, 406 U.S. 205 (1972), stated:

> "The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parent in the upbringing of their children is now established beyond debate as an enduring American tradition." 406 U.S. at 232.

This statement by the Court constitutes the capstone to a line of old, established and well-respected[6] cases which recognize, as in *Prince v. Massachusetts*, 321 U.S. 158 (1944), that:

> "It is cardinal with us that the custody, care and nurture of the child reside first with the parents, whose primary function and freedom include preparation for obligations the state can neither hinder nor supply." 321 U.S. at 166.

Through this line of cases this Court has clearly established a "private realm of family life which the state cannot enter" and established that the "sanctity of the family"[7] is constitutionally protected against State interference.

Hence, the State, both as a matter of tradition and as a result of this Court's decisions, is precluded in most instances from interjecting itself into the parents' decision-making process and from requiring parents to submit their decisions, once made, to scrutiny in an adversarial proceeding.

[6] *See Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923).

[7] *Moore v. East Cleveland*, _____ U.S. _____, 97 S.Ct. 1932 (1977).

A parent's constitutional right to family privacy and autonomy, particularly with respect to his child, is not without limits. However, the parameters established by this Court and others, which limit the parents' responsibilities and authority, are clearly predicated upon considerations having nothing to do with the parents' ability and responsibility to make medically-indicated decisions, with the concurrence of a physician, for their minor children[8]. Rather, these parameters are almost uniformly predicated on the concept that parents may not make certain types of decisions which, while requiring the services of a physician, are based on particular social or moral beliefs of the parents which may not reasonably be expected to be shared by the child.

Thus, this Court has held that parents may not prevent their unmarried minor child from obtaining an abortion, if the child so desires. *See Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976). Similarly, state courts have held that parents cannot have their children sterilized, irrespective of the parents' motivations where the health of the child is not involved. *See, e.g., L. v. H.*, 325 N.E. 2d 501 (Ind. 1975), *cert. denied*, 425 U.S. 936 (1976).

[8] In addition to the establishment by some courts of parameters beyond which parents may not make decisions for their minor children, other courts have established certain duties which parents must discharge. Notably, a great number of courts have held that parents and guardians have an obligation to provide proper medical treatment for their child and may be forced to provide such treatment if they do not do so voluntarily. *See Wallace v. Labrenz*, 411 Ill. 618, 104 N.E. 2d 769, *cert. denied*, 344 U.S. 824 (1952). Furthermore, these same courts have also held that the failure to provide the requisite medical attention for a child may constitute criminal neglect on the part of the parent or guardian. *See Singleton v. State*, 33 Ala. App. 536, 35 S. 2d 375 (1948); *State v. Beach*, 329 S.W. 2d 712 (Mo. 1959). Of course, in addition to these court decisions, most states have child abuse statutes which place restrictions on the authority of parents and guardians over their children. *See, e.g.*, Ga. Code § 26-2801.

Even though there are limits beyond which a parent may not go, a parent making a medically-indicated decision for his child, particularly when the decision is concurred in by a physician, has always, but for a few recent lower court decisions, been considered to be acting well within these parameters. *See Bartley v. Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975) *rev'd and remanded*, — U.S. —, 97 S.Ct. 1709 (1977); *Saville v. Treadway*, 404 F. Supp. 430 (M.D. Tenn. 1974). Unfortunately, the decision of the district court would change this general rule by holding that certain medically-indicated decisions of a parent, particularly those concurred with by a psychiatrist, must be subjected to scrutiny in an adversarial hearing before those decisions may be implemented.

As justification for this dilution of the authority of a parent to seek and obtain medical assistance for his child, the district court stated that:

> "[P]sychiatry according to psychiatrists is still an inexact science as to which there is the opportunity for wide, sincere differences of opinion among psychiatrists."[9]

The district court concluded, saying:

> "Since they are capable of erring, psychiatrists like parents cannot statutorily be given the power to confine a child in a mental hospital without procedural safeguards being interposed to guard against errors in judgment. . . ."[10]

With this language, the district court has tried to establish a yardstick by which to measure the extent of a parent's authority over his child. A parent's decision concerning the advisability of a particular type of medically-

[9] Opinion of the District Court, Juris. St. 51a.

[10] Opinion of the District Court, Juris. St. 52a.

indicated treatment is to be subjected to scrutiny in an adversarial proceeding, even if the decision is concurred with by a physician, whenever there is an "opportunity for wide, sincere differences of opinion" within the medical profession about the necessity of the treatment[11].

This new criterion, however, is based on substantially the same premise advanced by the State and rejected by this Court in *Doe v. Bolton*, 410 U.S. 179 (1973). There the Court, in overturning the State's requirement that a physician seek and obtain the concurrence of a number of his peers before performing an abortion, noted that:

> "If a physician is licensed by the State, he is recognized by the State as capable of exercising acceptable clinical judgment. . . . Required acquiescence by copractitioners has no rational connection with a patient's needs and unduly infringes on the physician's right to practice." *Id.* at 199.

Moreover, as this Court held in *Doe v. Bolton*, *supra*, the attending physician will recognize when a consultation is advisable, will recognize the "need for assurance when the medical decision is a delicate one."

Therefore, this Court and others have recognized that physicians can and should be trusted to provide competent medical assistance, and that requiring a review of

[11] Opinion of the District Court, Juris. St. 51a. The application of the district court's test could have some interesting but bizarre results. The Appellees' witness, Dr. Eli Messinger, indicated that the medical value of a tonsillectomy is questionable, concluding that ". . . I was myself a victim of a tonsillectomy. . . ." Testimony of Dr. Eli Messinger (A. 193). Using the district court's criterion of requiring the application of due process safeguards where there are sincere and wide differences of medical opinion concerning the necessity for a particular type of treatment, coupled with a risk to the patient's life or liberty, the medical decision as to whether to perform a tonsillectomy would require scrutiny in an adversarial proceeding, if performed in a public hospital.

the physician's exercise of the discretion vested in him is inappropriate. As the Supreme Court of New Jersey noted in the celebrated case of Karen Ann Quinlan[12], citing the lower court's decision:

> "Doctors . . . to treat a patient, must deal with medical tradition and past case histories. They must be guided by what they do know. The extent of their training, their experience, consultation with other physicians, must guide their decision-making processes in providing care to their patient. The nature, extent and duration of care by societal standards is the responsibility of a physician. The morality and conscience of our society places this responsibility in the hands of the physician. What justification is there to remove it from the control of the medical profession and place it in the hands of the courts?" 355 A.2d at 665.

Thus, the district court's conclusion that the decisions of physicians may be, and, in specific cases, must be scrutinized by courts or other independent observers, is thoroughly inconsistent with this Court's conception of the deference properly to be given to medical opinion, and also constitutes the "gratuitous encroachment upon the medical profession's field of competence,"[13] which other courts routinely avoid. For this reason alone the district court's decision should be reversed.

Additionally, the opinion of the district court should also be reversed for another reason. The district court's decision is predicated on the idea that psychiatrists and psychiatry are unreliable, because psychiatrists supposedly disagree routinely on the particular labels and diagnoses to be given to mentally ill persons.

[12] *In the Matter of Quinlan*, 70 N.J. 10, 355 A. 2d 647 (1976).

[13] *Id.* at 669.

It is true that not every diagnosis of a psychiatrist will be concurred in by all of his contemporaries, but there is little evidence in the record that psychiatry is an "inexact science," as the district court used that phrase.

By way of illustration, the evidence before the district court clearly indicated that the reliability of the diagnosis of a number of physical disorders is no better than the reliability of the diagnosis of mental illness[14]. While the diagnosis of mental illness may be complex, and while psychiatry may have been late in developing as a separate branch of medicine, it is difficult even for a layman to accept the validity of the proposition advanced by one of the Appellees' witnesses that in the past fifteen years no improvement has been achieved in the reliability of psychiatric diagnosis[15]. A better conclusion is that the substantial evidence in the record does not support the

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[14] "The issue that interests me was the reliability in schizophrenia versus the reliability in physical disorders, and when you look at the reliability in physical disorders, you find that the frequency of reliability is no better in a variety of physical disorders, from tonsillectomies to cardiac diseases to the pap smear, or the diagnosis for cancer of the cervix, as compared with diagnosis for the particular mental illness called schizophrenia." Testimony of Dr. Arthur Falek (A. 690). *See Falek and Moser, Classification in Schizophrenia*, 32 Arch. Gen. Psychiatry 59 (1975).

"The first study is an early investigation by Bakwin of the need for tonsillectomies in 389 children evaluated by three physician-observer groups. All of the children were examined by a first-observer group; those not considered in need of tonsillectomies were then evaluated by the second-observer group, and so on. Of interest is the fact that the 55.3% considered normal by the first-observer group was reduced to 16.7% by the time the third-observer group of physicians completed their examinations." [footnote omitted] *Id.* at 63.

"The difficulty in diagnosing angina is confirmed in a study of 57 chest pain patients; data on the consistency of diagnoses by three cardiologists for each of these patients evaluated after 15-minute interviews shows only a 45% concurrence among the three specialists." [footnote omitted] *Id.*

[15] Testimony of Dr. Eli Messinger (A. 192).

district court's conclusion as to the profession's lack of reliability but rather that the contrary is true[16].

Moreover, a great deal of the literature in the field of psychiatry disputes the Appellees' contention, and the district court's findings, as to the reliability of a psychiatric diagnosis. One measure of the reliability of a diagnosis of a condition is the consistency between independent diagnoses of that condition. Studies have demonstrated that independent physicians can reliably diagnose depression with correlations of .8 or .9 (80 to 90 percent agreement)[17]. Other studies have shown that reliability measures are also significant on self-rating scales[18] and highly reliable physiological measures and the physician's judgment of the severity of depression are correlated[19], all of which demonstrates a degree of reliability[20] in psychiatric diagnosis not recognized by the district court.

Indeed, the decision of the district court is internally inconsistent in this respect. On the one hand the district court decided that psychiatry was such an inexact science that the decisions of psychiatrists that hospitalization would be appropriate for a child had to be reviewed by

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[16] "It's like diagnosis in any field of medicine. It's not one hundred percent perfect, but the studies range from—if you're looking at observer agreement then it would be fifty-five percent, if you look at . . . diagnostic concordance, then you'd see figures as high as eighty-five, ninety-five, ninety-seven percent in some of the studies, so it's not something you can make a global statement about, that all psychiatric diagnoses are unreliable." Testimony of Dr. W. Douglas Skelton (A. 234).

[17] Bunney and Hamburg, *Methods of Reliable Longitudinal Observation of Behavior, 9* Arch. Gen. Psychiatry 114 (1963).

[18] Zung, *Self-Rating Depression Scale in an Outpatient Clinic*, 13 Arch. Gen. Psychiatry 508 (1965).

[19] Kupfer, *Interval Between Onset of Sleep and Rapid-Eye-Movement Sleep as an Indication of Depression*, Lancet 684 (Sept. 30, 1972).

[20] *See also*, Sandifer, *Psychiatric Diagnosis: A Comparative Study in North Carolina, London and Glasgow*, 114 Br. J. Psychiatry 1 (1968).

independent observers. Then the district court, in considering the disposition of the children, admitted:

> "It is not for this court of three lay judges to choose the appropriate, less drastic form of care for each of these children; that decision we leave to the professional judgment of the defendant psychiatrists."[21]

It is difficult to understand why the defendant psychiatrists cannot be relied upon to make a valid determination as to whether a child is suitable for treatment in a hospital, yet are evidently perfectly competent to determine that a child may be placed, perhaps against his will, in other settings which from all that the record discloses may involve the same or more stringent restrictions than hospitalization.

Moreover, the decision of the district court is even more difficult to understand in view of the fact that the court was unable to conclude that even a single child had been either not mentally ill or not suitable for treatment when initially hospitalized. The court in its opinion did not identify any child who could have benefited from the preadmission hearings mandated by the court.

This Court's decision in *Doe v. Bolton*, *supra*, recognizes the existence of a presumption that physicians are competent to make the medical decisions required of them, and the evidence supports the application of this presumption to the present case. To conclude with the finality of the district court's order that the decisions of psychiatrists are deserving of review constitutes an indictment of the psychiatric profession which is unwarranted, in conflict with the concepts established by this Court, and unsupported by the evidence in the record. To the extent that the decision of the district court is predicated

[21] Opinion of the District Court, Juris. St. 54a.

upon this unwarranted and unsupportable conclusion, it is clearly erroneous; it constitutes an unjustified intrusion into the constitutionally protected responsibilities of parents to guide the direction and upbringing of their children, as well as upon the right of a physician to practice his profession. It is a conclusion which the district court could not permissibly reach and which should be reversed.

II. WHEN A PARENT VOLUNTARILY SEEKS AND RECEIVES MENTAL HEALTH SERVICES FOR HIS MINOR CHILD FROM A STATE AGENCY, THERE IS INSUFFICIENT "STATE ACTION" TO IMPLICATE THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT TO THE CONSTITUTION OF THE UNITED STATES.

Argument I, *supra*, was concerned with the issue of whether, when a parent makes a medically-indicated decision for his minor child, the State, through its judiciary or otherwise, has any authority or duty to require that the parent submit his decision to an adversarial challenge.

A closely related issue is whether, when the parent receives medical assistance or services from a State mental health facility, the parent's decision-making process is thereby imbued with that quantum of "state action" necessary to implicate the Due Process Clause of the Fourteenth Amendment to the Constitution.

The issue of what state involvement transforms private action into "state action" has been widely debated. One conclusion which is almost universally accepted is that not every service or benefit provided to a private party by a state will cause the private action to be subjected to

the limitations imposed by the Fourteenth Amendment[22].

More particularly, there is a constant thread throughout the case law on "state action," that in each instance the state must be found to have either: (1) affirmatively delegated its power to the entity engaging in the activity sought to be prohibited[23]; (2) so intertwined its activities with the private activities complained of that the state's interests and the private interests are inseparable[24]; or (3) encouraged, enforced, or affirmatively aided or supported the activity sought to be prohibited[25].

While no objective test, applicable to every situation, for determining the presence of "state action" has been formulated, it is clear that state involvement in a private activity does not constitute "state action" unless it appears that the state involvement creates, aids, encourages or enforces the activity.

In this case neither the admission of a child to a State mental health facility nor the services provided the child and parent after the child's admission constitutes "state action."

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[22] In *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163, 173 (1972), it was noted that: "The Court has never held . . . that discrimination by an otherwise private entity would be violative of the Equal Protection Clause if the private entity receives any sort of benefit or service at all from the State. . . . Since state-furnished services include such necessities of life as electricity, water and police and fire protection, such a holding would utterly emasculate the distinction between private as distinguished from state conduct. . . ."

[23] *Adickes v. S.H. Kress Co.*, 398 U.S. 144 (1970).

[24] *Burton v. Wilmington Parking Authority*, 365 U.S. 715 (1961).

[25] *Reitman v. Mulkey*, 387 U.S. 369 (1967); *Shelley v. Kramer*, 334 U.S. 1 (1948).

A. The decision of the parent to seek treatment for his mentally ill child in a State mental health facility does not constitute "state action" for the purposes of the Due Process Clause of the Fourteenth Amendment to the Constitution.

The statute challenged here does not purport to grant to the parents of a mentally ill child the right to cause that child to receive whatever treatment the parent determines is medically indicated. The challenged statute merely authorizes the superintendent of a facility to admit a child on the application of his parents if in fact the child is mentally ill and suitable for treatment.

The authority of the parents comes, instead, from the traditional relationship between a parent and his child, the origins of which were discussed in Argument I, *supra*. This relationship is clearly supported by the decisions of this Court, which have recognized the parents' responsibility to raise and care for their children in the manner they deem most appropriate[26].

Thus, the ultimate decision as to whether to hospitalize a child rests with his parents. The function of the State under the challenged statute is to provide a resource if it is needed, and to provide a system to insure that the State does not become party to unnecessary hospitalizations. The superintendent does not decide that the child will be hospitalized; he merely decides whether the hospital will be made available for a particular placement.

This distinction is significant because parents can refuse to seek admission for a child even when the superintendent would find hospitalization appropriate, and parents can remove a child from the hospital even if the

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[26] *See, e.g., Wisconsin v. Yoder*, 406 U.S. 205 (1972); *Meyer v. Nebraska*, 262 U.S. 390 (1923).

superintendent believes that continued hospitalization would be appropriate[27].

Thus, unlike the situation in *Reitman v. Mulkey*, 387 U.S. 369 (1967), and cases of that genre, the State is not actively encouraging the hospitalization of children, nor does the State, through the challenged statute, convey to the parents the power to effectuate the hospitalization. Rather, the State's position is more akin to the government's position in *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345 (1974), where this Court noted:

> "Approval . . . of such a request (for authority to terminate services to a customer by a public utility) . . . where the commission has not put its own weight on the side of the proposed practice by ordering it, does not transmit a practice initiated by the utility and approved by the commission into 'state action'. . . . Respondent's exercise of the choice allowed by law where the initiative comes from it and not from the State, does not make its action in doing so 'state action' for the purpose of the Fourteenth Amendment." *Id.* at 357 [Parenthetical matter added].

Here, as in *Jackson v. Metropolitan Edison Co.*, the challenged law merely offers a private party a choice. The State does not order children hospitalized nor does it seek out prospective patients. It simply makes available an alternative, which parents or guardians are free to select, if appropriate, or reject. It is the parents' or guardians' initiative and their decision, that result in the hospitalization of the child, rather than the actions of the State.

Moreover, for this Court to determine that the provision of this resource constitutes "state action" would

[27] Testimony of Dr. James Craig (A. 530).

result in fundamental unfairness. Parents are completely free to take their children to a private mental health facility, if they wish. If they do, and the child is admitted, the child is offered none of the procedures sought in this lawsuit. The child can be placed in the private institution and kept there indefinitely without ever having an opportunity to challenge his hospitalization in the manner ordered by the district court. Society and the State rely, as this Court in *Doe v. Bolton, supra*, determined that they should, on the medical judgment of the physicians at such facilities to see that proper services are provided.

Yet under the district court's decision, whenever a parent exercises the choice given by the challenged law, he will find himself faced with an adversarial hearing, the expense of a lawyer and, in essence, an undesired and undeserved confrontation with his ill child. The fact that the parent has selected, for whatever reason, a State mental health facility rather than a private facility, provides neither a sufficient nor a reasonable basis for concluding that "state action" is present.

B. The activities of the State, after a child is admitted to a State mental health facility, do not constitute "state action" for the purposes of the Due Process Clause of the Fourteenth Amendment to the Constitution.

This lawsuit does not challenge the quality of care rendered to hospitalized children, but rather complains of a perceived lack of due process in the procedures resulting in hospitalization and the continuance of hospitalization once begun. Just as there is no "state action," using the criteria set forth previously, in the decision to hospitalize the child, neither is there sufficient "state action" in continuing the hospitalization to implicate the Due

Process Clause of the Fourteenth Amendment.

Once a child is admitted to the hospital, by the terms of the challenged statute, the child is classified as a voluntary patient and, with one exception, the child has all the rights of any voluntary patient.

Among the rights which each voluntary patient has is the right to request his discharge at any time after five days following his admission to the facility[28]. That is, when a voluntary patient requests his discharge, the superintendent must discharge the patient unless he finds the discharge would be unsafe to the patient or others, in which case the State's involuntary hospitalization procedures, which have not been challenged in this suit, must be followed.

The exception noted is that the statute provides if the voluntary patient was admitted upon the application of his parent or guardian, the patient's discharge prior to his becoming eighteen years of age may be conditioned upon the consent thereto of his parent or guardian.

The reason for this exception is well-founded. The criteria for admission of a voluntary patient are merely that the patient be mentally ill and suitable for treatment. An adult, however wrong the decision may be, is free to choose to leave the hospital even though he is still mentally ill and his illness may be suitable for treatment at the hospital, for he is assumed to be capable and compe-

[28] Ga. Code § 88-503.3. "A voluntary patient who is admitted to a facility pursuant to section 88-503.1, or his legal guardian, parent, spouse, attorney or adult next-of-kin, may request his discharge in writing at any time after five days following his admission to the facility. . . . If the patient was admitted before the age of 18 on the application of his parent or guardian under section 88-503.1, his discharge prior to becoming 18 years of age may be conditioned upon the consent thereto of his parent or guardian."

tent to assume the risk attendant upon being discharged from the hospital against the medical advice of his attending physician.

However, children cannot be treated as adults, with respect to receiving medical treatment. Children oftentimes do not appreciate that medical treatment is for their own good and thus may attempt to avoid receiving medical treatment for reasons which are neither rational nor logical[29]. For this reason, the statute recognizes the responsibility of the parent, or guardian, to determine whether his mentally ill child, who is still suitable for treatment in the mental health facility, may assume the risk of leaving the hospital against medical advice. The decision that the mentally ill child must remain is made solely by the parent or guardian, and the mental health facility may not make that decision for the parent, as long as the child does not meet the criteria of the State's involuntary commitment statute[30]. The State's involvement is reduced to the responsibility of every medical facility, whether private or public: the rendering of medically-indicated treatment upon the request of the person, or one legally responsible for the person.

Interestingly enough, as noted before, not only does the parent have the right to make the independent deci-

[29] Testimony of Dr. John Filley (A. 744). Dr. Eli Messinger concurred stating: "I would say to the parents that they should use their authority to bring the child in and I would explain to the child that whether he liked it or not, we as adults saw this as a grave situation and that perhaps he didn't understand it now, but we assumed that he would eventually understand our action." Testimony of Dr. Eli Messinger (A. 208).

[30] The Georgia Code provides that a person may be involuntarily committed to a State mental health facility if the person is (1) mentally ill and (2) either likely to injure himself or others if not hospitalized or is incapable of caring for his physical health and safety. Ga. Code § 88-506.1.

sion that the child is to remain in the hospital, even though the child does not desire to do so, but the parent also has the authority to withdraw the child from the hospital at any time, irrespective of the fact that the child is still mentally ill, is still suitable for treatment and may prefer to remain in the hospital. The State is helpless to prevent this from occurring unless the State either seeks to involuntarily hospitalize the child, utilizing the involuntary hospitalization procedures of the Georgia Mental Health Code, or files a petition in the juvenile court alleging that the parents are depriving the child of proper medical treatment through their action.

Thus, the decision to maintain a child in a State mental health facility, if the child is mentally ill and suitable for treatment, or to remove the child from the facility, is a decision which can only be made by the parent or guardian. The hospital acts as a provider of medical services, not as a prison. The State is simply another provider of services obtainable from any number of private facilities; to assert that this rises to the level of "state action" is to make a mockery of the concept that not every instance of state involvement in private activities implicates the Due Process Clause of the Fourteenth Amendment.

III. THE CHALLENGED STATUTE AND THE ADMINISTRATION OF THAT STATUTE SATISFY THE CONDITIONS IMPOSED BY THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT TO THE CONSTITUTION OF THE UNITED STATES.

Even if the district court was correct in determining that a parent's decision to hospitalize a mentally ill child in a State mental health facility mandates a system of checks and balances to insure that parents do not abuse

their authority, the district court's conclusion as to the scope of "what process is due" was erroneous.

It is axiomatic that not every infringement upon a constitutional right requires the same form of due process[31]. Instead this Court has held, as in *Mathews v. Eldridge*, 424 U.S. 319 (1976), that the identification of the specific dictates of due process in any particular situation generally requires consideration of three distinct factors: (1) the private interest that will be affected by the official action; (2) the risk of an erroneous deprivation of such interest by the procedures presently used, and the probable value, if any, of additional or substitute procedural safeguards; and (3) the government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirements would entail.

The applicability of these criteria to the present case and the result thereof are clearly affected by this Court's recent decision in *Ingraham v. Wright*, — U.S. —, 97 S.Ct. 1401, 51 L.E.2d 711 (1977), involving the question of children's rights to procedural due process safeguards prior to the imposition of corporal punishment, and *Smith v. Organization of Foster Families for Equality and Reform* (hereinafter cited as OFFER), — U.S. —, 97 S.Ct. 2094 (1977), having to do with the sufficiency of protections afforded by New York to foster parents upon the removal of their foster children.

Each of these considerations will be examined separately.

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[31] *See, generally, Goss v. Lopez*, 419 U.S. 565 (1975); *Morrissey v. Brewer*, 408 U.S. 471 (1972); *Cafeteria Workers v. McElroy*, 367 U.S. 886 (1961); *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306 (1950).

A. The challenged statute successfully balances the right of a parent to exercise control over the care and upbringing of his child, with the child's limited right to liberty.

Any consideration of the first factor noted in *Mathews v. Eldridge*, *supra*, *Ingraham v. Wright*, *supra* and *OFFER*, *supra*, must immediately focus on the number of competing private interests which are involved in this suit. Here the principals, irrespective of how the case is styled, are parents and their children, and the particular interests affected by the case are the rights of the parents to seek medically-indicated treatment for their child, as opposed to the child's right to contest his hospitalization in a State mental health facility. These interests are competing and the procedural rights of the child can only be expanded at the expense of the rights of the parents. That is, if the child is afforded the due process procedures which the district court has mandated, the right of the parent to determine what medically-indicated treatment is to be provided to his child, must necessarily be narrowed.

In determining where the proper balance lies, it is significant to note that the constitutional interests involved are not of the same magnitude. Historically, this Court has recognized that the parent has a right to determine the type of care to be given to the child, within certain parameters, and that the State has no authority to interfere in these decisions. *See Wisconsin v. Yoder*, *supra*; *Prince v. Massachusetts*, *supra*.

On the other hand, a minor's liberty interest, *vis-a-vis* the State, is limited. For instance, the State can limit a minor's access to certain types of books[32], can affect a

[32] *Ginsberg v. New York*, 390 U.S. 629 (1968).

minor's right to vote[33], can limit a child's access to alcoholic beverages[34], and can even limit a child's ability to earn a livelihood[35]. Further, even though this Court in *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52 (1976), has held that parents may not exercise an absolute veto over their minor child's right to an abortion, this Court did recognize in *Bellotti v. Baird*, 428 U.S. 132 (1976), that a statute which gives a parent some control over the minor's decision to have an abortion, and which forces the minor child to seek court approval of the abortion, may be constitutionally appropriate, even though similar strictures could not be placed upon an adult.

In determining the nature of the child's liberty interest in the present case, reliance on such cases as *In re Gault*, 387 U.S. 1 (1967) and *McKeiver v. Pennsylvania*, 403 U.S. 528 (1970), is misplaced. In each of those cases and its progeny, the children involved had run afoul of the laws of the State, laws in which the State had an enforcement interest. The rights of the juvenile were in conflict with the State interest in enforcing its own laws. "Such due process cases are inapplicable to a case such as this where the state interest . . . coincides perfectly with [the child's] interest." *Drummond v. Fulton Co. Dept. of Family and Children Services*, 547 F.2d 835, 860 (5th Cir. 1977) (Roney, J., dissenting) (rehearing *en banc* granted).

Thus, what is actually at issue is whether the present procedures used to provide for the hospitalization of a mentally ill child are so fraught with the possibility of error on the part of the parent and the physician that the

[33] *Oregon v. Mitchell*, 400 U.S. 112 (1970).

[34] *Republician College Council of Pennsylvania v. Winner*, 357 F. Supp. 739 (E.D. Pa. 1973).

[35] *Prince v. Massachusetts*, 321 U.S. 158 (1944).

parent's very broad responsibility to see to the care and welfare of his child must be limited and the limited rights of the child expanded through the imposition of more rigorous procedural impediments to hospitalization.

B. The risk of an erroneous deprivation of the child's liberty interest, with the procedures presently used, is inconsequential and the probable value of additional or substitute procedures is insignificant.

The second factor noted in *Mathews v. Eldridge*, *supra*, *Ingraham v. Wright*, *supra*, and *OFFER*, *supra*, involves an evaluation of (1) the risk of an erroneous deprivation of a child's liberty interest by the procedures presently used to hospitalize a child; and (2) a consideration of the probable value of additional or substitute procedural safeguards. The evidence presented to the district court clearly indicates that the procedures presently[36] used are

[36] The remarks of the dissent by Judge Roney in *Drummond v. Fulton Co. Dept. of Family & Children Services*, 547 F. 2d 835, 860 (5th Cir. 1977) [rehearing *en banc* granted], made in reference to Georgia's foster care system, seem so pertinent to the mental health delivery system as to warrant extensive quotation:

"The [physicians and parents] who made the decision about [the Appellees] were more intimately acquainted with them, their past history and any potential problems, than any hearing officer [or judge] could ever be. I think that this form of rational decision making is all that is required. Due process does not mean the kind of adversarial hearing with which courts are so familiar. The factors that must be weighed in deciding if a [mentally ill] child could have a successful [treatment] in a particular [setting] are so complex and ephemeral that adversarial procedures are inappropriate. The [professional] system of [mental health services] established by the state for the processing of these very difficult personal and social decisions should not be destroyed under a constitutional edict. Limitations of time, money and human resources may well dictate the methodology of the state agency, but as long as all legal interests of the parties are reasonably protected, the state procedure is not subject to constitutional supervision." [Bracketed matter added].

sufficiently thorough so as to essentially preclude the risk of an erroneous deprivation of the child's liberty and the district court's conclusion to the contrary was erroneous.

Initially, the evidence presented to the district court demonstrated that, with the exception of emergency admissions, children are normally referred to community mental health centers prior to any consideration of their admission to a hospital[37]. In most instances, only after community resources have either been eliminated or exhausted, are the children brought to the regional hospitals[38].

Once it is determined that the child cannot be treated in the community and that hospitalization may be indicated, the child is subjected to a thorough screening procedure at each regional hospital[39]. While a physician makes the ultimate determination that a child is to be admitted to a hospital, the evaluation of the data available involves a "team" approach involving not only the

[37] "[T]he child is admitted through a community program. To explain that further, it is our feeling that children should not simply be admitted directly to the hospital. . . . So any referral for admission is first of all processed, or evaluated, by community mental health people, and then, if institutional admission is to be considered, the institutional staff is involved in a final determination of what the treatment plan will be for that child, and that child's family." Testimony of Dr. Eugene Jarrett, III, (A. 443); *See also* testimony of Drs. Bowling, (A. 355); Mazur, (A. 479); Craig, (A. 522); and Gates, (A. 280).

[38] "[T]he basic philosophy of the hospital, is that persons will be treated in the comprehensive community mental health centers in every possible instance, rather than being hospitalized." Testimony of Dr. Lawson Bowling, (A. 355); *See also* testimony of Drs. Jarrett, (A. 446); and Mazur, (A. 481).

[39] *See, e.g.*, Dfs. Ex. 4 to testimony of Dr. John Gates, (A. 322, 283); Dfs. Ex. 2 to testimony of Dr. James Craig, (A. 548, 522); and Dfs. Ex. 2 to testimony of Dr. Lawson Bowling, (A. 384, 353).

psychiatrist, but social workers, psychologists and other mental health professionals[40].

Moreover, the evidence presented to the district court indicated that the persons making the decision were not required to make that decision based solely upon their observations of the child and information supplied by his parents. The testimony of the superintendents clearly indicated that, as a part of the screening procedures, information was actively sought from the community mental health centers involved and that contact was made in various instances with the child's school, the child's parents, other relatives, county departments of family and children services, local law enforcement agencies and even courts, when appropriate[41]. Thus, the decision by the hospital that a child is suitable for treatment is not an "unchecked and unbalanced" decision made by a single psychiatrist acting in a vacuum, but rather is the result of a procedure involving input from a number of different persons and from a number of different sources.

Perhaps the most interesting point of the district court's opinion, with respect to this issue, is not what the opinion said, but what it did not say. The district court's opinion is very lengthy and detailed, yet the district court did not identify a single child who was at the time of his initial hospitalization neither mentally ill nor un-

[40] "[T]he kinds of persons that are involved . . . are called screening coordinators, who are appointed by the program director of the . . . children's service, and . . . [include] . . . social workers, psychologists, an assistant director of education and a psychiatrist." Testimony of Dr. Bowling, (A. 358). *See also*, testimony of Drs. Gates, (A. 280); Kuglar, (A. 558); and Mazur, (A. 508).

[41] "[The staff] also try to contact any other people [parents, relatives, schools, D.F.C.S., juvenile courts] who may have been involved with this child prior to admission to see what information they can gather that would bear on the disposition of the child." Testimony of Dr. John Gates, (A. 284).

suitable for treatment in the hospital. The district court did not find that J.L., J.R. or any member of the class they represent had been initially hospitalized inappropriately. The Court found instead that forty-six of the children in the hospital "could now be treated and cared for in non-hospital surroundings if such were only available."

In evaluating the risks of an erroneous deprivation of a child's liberty under the present procedures it is significant that the district court's opinion is absolutely silent as to any specific instance where the admission system had proved faulty. Certainly the district court found that on occasion when a child is ready to leave the hospital, there is no place ready to receive him, but the district court's opinion does not in any way demonstrate, or find as a fact, that the difficulties that a child has in finding a place to go could have been prevented by a preadmission hearing.

Even though some children may remain in the hospital when other settings may be more appropriate, this does not result from a failure in the admission procedures or through the failure of the hospital to identify their needs. Each superintendent indicated that there existed in each of the institutions a policy requiring periodic reviews of the status of each patient to determine whether the child continued to be mentally ill and suitable for treatment at the hospital[42]. The viability of this review system is clearly supported by the fact that fifty percent of all the children admitted to State hospitals are released within

[42] "[T]he 'staffing procedure' . . . involves an initial assessment of the problem, the formulation of the treatment plan, and . . . that is followed up by the regular rounds at which that is reviewed. . . . There's a review of each case once a week." Testimony of Dr. Lawson Bowling (A. 359).

sixty days after admission, and eighty percent are released within six months[43].

However, if a child has been inappropriately hospitalized, or remains hospitalized when hospitalization is no longer appropriate, the Georgia Code contains a number of provisions which may be immediately utilized to remedy the situation.

Specifically, Ga. Code § 88-502.11(b) provides that a patient or his representative may file a petition in the probate court of the county in which the patient is hospitalized, alleging that a procedure authorized by Ga. Code Ch. 88-5 is being abused[44]. Thus, if a child is hospitalized who is not mentally ill or if a child is hospitalized who is not suitable for treatment, or if the superintendent of a facility retains a child after a reasonable person would conclude that hospitalization is no longer desirable, the probate court of the county in which the hospital is located has an absolute and unfettered right to correct the situation by ordering the child released from the facility or by ordering whatever other relief may be appropriate.

In addition to the provisions of Ga. Code § 88-502.11(b), Ga. Code § 88-502.11(a) provides that at any time and

[43] The evidence presented to the district court clearly established that the hospital personnel had established contact and actively sought the removal of the Appellees from the State hospital, when the hospital personnel determined that there existed another treatment setting which might be more appropriate for the Appellees. Testimony of Ann Etheridge, (A. 658-59).

[44] Ga. Code § 88-502.11(b) provides as follows: "A patient or his representatives may file a petition in the probate court in the county in which the patient is hospitalized, alleging that the patient is being unjustly denied a right or privilege granted by this Chapter or that a procedure authorized by this Chapter is being abused. Upon the filing of such a petition, the court shall have the authority to conduct a judicial inquiry and to issue any appropriate order to correct any abuse of the provisions of this Chapter."

without notice a person detained in a facility, or a relative or friend of such person, may petition for a writ of habeas corpus to question the cause and legality of the detention of the person[45]. Hence, again, if a child is either not mentally ill or is improperly hospitalized, the Code makes specific provision for an application for a writ of habeas corpus to challenge the legality of the confinement.

Finally, Ga. Code Title 24A, the Juvenile Court Code of Georgia, makes specific provision for children who have been (1) placed for care in violation of law or (2) who have been abandoned by their parents or other legal guardians by declaring such children to be "deprived."[46] Georgia Code § 24A-1602 provides that any person has standing to file a petition, alleging the deprivation of a child. If the juvenile court, after hearing, finds that the child is not being cared for properly or is otherwise deprived, the juvenile court has complete and unlimited jurisdiction to make suitable provisions for the child. Appellees have not suggested, nor could they show, that these statutory remedies are ineffective.

In addition to providing these remedies, the Georgia Code provides that the State's Department of Human Resources must see that each patient is given the opportunity to secure legal counsel to represent him in these

[45] Ga. Code § 88-502.11(a) provides as follows: "At any time and without notice, a person detained by a facility or a relative or friend on behalf of such person may petition, as provided by law, for a writ of habeas corpus to question the cause and legality of detention and to request the court on its own initiative to issue a writ for release."

[46] Georgia Code § 24A-401 provides *inter alia*, that a deprived child is a child who "(2) has been placed for care or adoption in violation of law; or (3) has been abandoned by his parents or other legal custodian."

matters[47]. Counsel for Appellees were provided office space by the very persons they are now suing. Moreover, it was the staff of the hospital itself that referred Appellees to their counsel.

The system created by the Georgia Code for the voluntary hospitalization of mentally ill children works, and works well. For those very few instances where the system might fail, there are sufficient legal remedies, meaningful legal remedies, so as to preclude a wholesale rejection of the voluntary hospitalization process, as is advocated by the Appellees.

In addition to the issue of the efficacy of the present procedures surrounding the hospitalization of children, the second factor set forth in *Mathews v. Eldridge*, *supra*, *Ingraham v. Wright*, *supra*, and *OFFER*, *supra*, requires an examination of whether any additional procedures or safeguards would provide a better method of insuring that the liberty interest of the children, however limited, is better protected. Although the evidence is in conflict, the overwhelming bulk of the evidence presented to the district court indicates that additional or more formalized procedures are unnecessary, and in fact that such procedures may be harmful and detrimental to the children.

Appellees in their complaint, in essence, asked for a hearing replete with all the trappings normally associated with an adversarial proceeding, including the right to counsel, the right to subpoena witnesses, the right to cross-examine the person seeking the hospitalization for

[47] Ga. Code § 88-502.12 provides as follows: "It shall be the responsibility of the department to see that every patient is given the opportunity to secure legal counsel to represent him in connection with private, personal, domestic, business, civil, criminal, and all other legal matters in which he may be involved during hospitalization."

the child, and a host of other rights more compatible with a criminal proceeding than with the hospitalization of a mentally ill child.

As justification for more formalized proceedings, Appellees' position is that such a proceeding would result in the production of more information, which would provide a better foundation for making the decision whether to hospitalize the child either by opening up new sources of information or by providing a forum in which a more complete and accurate examination of the child's needs could be made.

However, the Appellants' evidence demonstrated that all of the sources of information which Appellees' witnesses felt were important were already known to the superintendents, and were utilized[48]. Furthermore, the evidence clearly indicated that mental health personnel are trained specifically to elicit information concerning the condition of prospective patients, and that it is doubtful that a lawyer on cross-examination could get any more beneficial information than could a psychiatrist through the application of skills particularly cultivated for that purpose over a period of years[49].

[48] *See, e.g.*, testimony of Drs. Jarrett (A. 467); and Miles (A. 250).

[49] "[A] normal part of training that [mental health professionals are] taught is to look at things in terms of the complex system of dynamics in which people function." * * * "I really can't imagine a more extensive information system, gathering system, than we have now in dealing with families [or] . . . information that can be presented within a couple of hours of a hearing that's going to be of any significant help to me, except in very rare cases." Testimony of Dr. John Filley, (A. 751), (A. 780).

Indeed, this Court itself has recently expressed a similar opinion that appointment of attorneys or other adult representatives would not be necessary, "since the appointed representative's inquiry into the best interests of the child would essentially duplicate that already conducted by the agency. . . ." *OFFER*, *supra*, 97 S. Ct. at 2114, n. 59.

On the other hand, each of the superintendents of the State mental health facilities, as well as other witnesses, questioned about the subject, stated that he would be opposed to any type of judicial proceedings to determine whether a child should be hospitalized. Their reasons were varied, but they centered around the facts that (1) a judicial hearing could not add any more factual information than the hospital could obtain on its own, and (2) the adversarial nature of the hearing would detrimentally affect the mentally ill child[50]. One of Appellants' witnesses, Dr. John Filley, a child psychiatrist, testified that such a proceeding would be quite disruptive. The doctor noted that:

> "[G]oing to the hospital because you have something wrong with you is not that strange. Most kids, as they grow up, know and have found out that you go to a hospital because you have something wrong with you and consult with a doctor, and that seems to be the best thing to do. . . . Due process proceedings in the court, witnesses and so on are much more alien in a child's life and airs all the dirty linen, not all of it probably, but it airs a significant amount of dirty linen in the child's life and parents' lives." [51]

[50] "[I]t's my opinion that where mental illness exists, that physicians and staffs of community mental health centers are trained and experienced in recognizing those conditions, and that the subjecting of a mentally ill child to a courtroom procedure could be detrimental to [him]—could cause him anxieties and tensions, fears, that in my opinion would not be necessary." Testimony of Dr. Lawson Bowling, (A. 366). *See also*, testimony of Drs. Miles, (A. 261); Kuglar, (A. 568); Mazur, (A. 487); Craig, (A. 530-31); and Gates (A. 293-94).

[51] Testimony of Dr. John Filley, (A. 756). Notably, the children's primary witness, Dr. Eli Messinger, who testified concerning the benefit of such a proceeding, had to admit that he had never experienced an adversarial proceeding involving a child such as that contemplated by the district court's order. (A. 216).

Similarly, other people intimately familiar with the processes of the juvenile court concurred with the Appellants' witnesses. As one judge noted:

> "Adversarial hearings in the juvenile courts are often emotionally traumatic. Placing a parent and a child in an adversarial situation when in fact they do not wish to be adversaries, and when in fact the parent is only seeking the best for his child, would, in my opinion, harm the family relationship." [52]

Therefore, the evidence clearly demonstrates that the procedural safeguards sought by the children would not improve the determination of whether a child should be placed in a mental hospital for treatment for his mental illness, and the evidence in fact indicates that the contrary may well be true: that forcing parents to proceed through adversarial hearings in which they are pitted against their child may result in (1) delay by parents in seeking mental health treatment for their child beyond the time which they do now[53]; and (2) compounding the child's existing problems by forcing him to engage in an adversarial hearing, irrespective of whether he desires to do so.

On balance, therefore, it is unlikely that any of the additional safeguards sought by Appellees would materially enhance the protections given to children under the present administration of the challenged statute, and in the absence of some affirmative showing of the benefit flowing from the addition of such procedures, it is evident that the district court erred in holding that such procedures are necessary.

[52] Affidavit of Judge Romae T. Powell, (A. 924).

[53] "There might be quite a number of parents who would not want to get into that sort of a situation [adversarial hearings], but who would be able to work quite effectively with a hospitalization and return after a period of treatment. . . ." Testimony of Dr. John Filley, (A. 757).

C. The benefits of imposing additional due process procedures would not justify the burden placed on the State by such procedures.

As was noted in Argument III B, *supra*, there is a serious question as to whether the additional procedures advocated by the Appellees would not in fact prove detrimental to the children. There is no question, however, as to the costs of such safeguards to the State. As this Court noted in *Ingraham v. Wright, supra:*

> "Hearings—even informal hearings—require time, personnel, and a diversion of attention from normal school pursuits. School authorities may well choose to abandon corporal punishment rather than incur the burdens of complying with the procedural requirements." 51 L.E.2d at 736.

Similarly, the imposition of the additional safeguards sought by the Appellees in the present case will impose substantial burdens on the State. In most instances attorneys will have to be provided for the children involved. Under the Juvenile Court Code[54] parents may have to be provided with an attorney if there is any possibility that the parents' rights with respect to the child may be affected. Hospital personnel will be required to leave their duties at the hospital to travel to these hearings, with the concomitant loss in time available to serve the hospital's patients.

Finally, the evidence indicates, notwithstanding the district court's findings to the contrary, that two of the judges of the juvenile courts of Georgia's most populous counties perceived the district court's order as imposing

[54] Ga. Code Ch. 24A-41 provides that if the challenged statute is stricken, further admission of children to hospitals will be accomplished through the juvenile courts. *See* App. A to this brief.

a substantial burden on the operation of their courts. More particularly, while the statistics utilized by the district court seem to obviate the danger of any great burden being placed on the juvenile courts, the judges, who are most knowledgeable as to the ability of their courts to handle additional hearings for mentally ill children, provided evidence that their courts were overcrowded[55], that their facilities and personnel were neither equipped nor trained to deal with mentally ill children[56], and that the burden of such hearings would clearly outweigh the benefits which would be received by the children. Such evidence should not be treated lightly when this Court considers the impact of the district court's order on the State.

This Court concluded, in *Ingraham v. Wright, supra,* that:

> "In view of the low incidence of abuse, the openness of our schools, and the common law safeguards that already exist, the risk of error that may result in violation of a schoolchild's substantive rights can only be regarded as minimal." *Id.* at 737.

Substantially the same conclusion is dictated by the record in the present case. To hold otherwise will only result in an imposition on the rights of parents and a diminution of State resources, all in order to obtain additional procedural safeguards which most agree will be harmful to the very children the Appellees say they wish to protect.

[55] Affidavit of Judge Romae T. Powell, (A. 919).
[56] Affidavit of Judge Dennis F. Jones, (A. 930).

IV. IF A PARENT OR GUARDIAN OF A MENTALLY ILL CHILD SELECTS, WITH THE ASSISTANCE OF A PHYSICIAN, A STATE MENTAL HEALTH FACILITY AS A SUITABLE PLACE FOR THE CHILD'S TREATMENT, THE STATE SHOULD NOT BE PROHIBITED FROM PROVIDING THAT SERVICE MERELY BECAUSE ANOTHER TREATMENT SETTING MIGHT BE "MOST APPROPRIATE".

A. Applying the "less drastic means" doctrine to the providing of treatment to mentally ill children is inappropriate.

As a corollary to its holding that parents and guardians cannot voluntarily admit their children to State mental health facilities, the district court also concluded that each mentally ill child must be treated in the setting considered "most appropriate" to his condition.

The court noted that there were many[57] alternative treatment settings which conceivably might be appropriate for mentally ill children, but left the selection of the optimal, "less drastic form of care for these children" to the "professional judgment of the defendant psychiatrists."[58] With this brief allusion to the "less drastic means" theory[59] the district court has expanded a care-

[57] *E.g.*, small group crisis home; small group home; specialized small group living home; small group home clustering; therapeutic camp life; specialized foster parent program; rotating parent program; home care services; and private child care agencies. Opinion of the District Court, Juris. St. 54a.

[58] *Id.*

[59] Commentators use various labels for this theory such as the principle of the "least restrictive alternative" [*see, e.g.*, Chambers, *Alternatives of Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 Mich. L. Rev. 1107 (1972)]; principle of "less drastic means" [*see, e.g.*, Note, *Less Drastic Means and the First Amendment*, 78 Yale L. J. 464 (1968)]; or as the principle of "reasonable alternatives" [*see, e.g.*, Wormuth and Mirken, *The Doctrine of Reasonable Alternatives*, 9 Utah L. Rev. 254 (1964)]. However, since this Court has not settled on a particular designation, Appellants believe it to be more accurately framed in reference to the "most appropriate" setting.

fully tailored constitutional doctrine in a fashion not contemplated by other courts.

The legal theory upon which the "less drastic means" doctrine is predicated is quite simple. It is based on the principle that:

> "[E]ven though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be narrowly achieved. The breadth of legislative abridgement must be viewed in the light of less drastic means for achieving the same basic purpose." *Shelton v. Tucker*, 364 U.S. 479, 488 (1960).

The "less drastic means" doctrine has been applied to the area of mental health law in two aspects of the involuntary civil commitment process: as part of an inquiry into alternatives to institutionalization[60] and to maximum security treatment within the institution itself.[61] However, the importation of this theory into the complex area of mental health law has not been without dissenters who note accurately that a "court in our legal system is not set up to initiate inquiries and direct studies of social welfare facilities or other social problems."[62] Not only is this theory subject to criticism in its constitutional dimensions *vis-a-vis* involuntary commitments[63], but care-

[60] *E.g., Lake v. Cameron*, 364 F.2d 657 (D.C. Cir. 1966).

[61] *E.g., Covington v. Harris*, 419 F.2d 617 (D.C. Cir. 1969).

[62] *Lake v. Cameron, supra*, at 663 (Burger, C. J., dissenting).

[63] *Compare State v. Sanchez*, 80 N.M., 438, 457 P.2d 370 (1969), *appeal dismissed for want of a substantial federal question*, 396 U.S. 267 (1970) (holding that the state need not consider less drastic alternatives to hospitalization), *with Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated on procedural grounds*, 414 U.S. 473 (1974), on remand 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated on procedural grounds*, 421 U.S. 957 (1975), on remand, _____ F. Supp. _____ (E.D. Wis. 71-C-602, May 28, 1976) (*contra*).

ful analysis demonstrates that it is totally inappropriate to attempt to twist the doctrine to apply to the voluntary hospitalization of mentally ill children.

All adults share basically the same right to liberty, meaning both freedom from bodily restraint and freedom to choose the direction of their own lives without unwarranted restriction by either the State or their fellow citizens. Any restriction imposed upon an adult can be measured against this single "baseline," and it is this ability to compare the freedom that an adult actually has, with what he could rightfully expect to have, which gives meaning to the "less drastic means" doctrine.

Children, however, do not have the same rights as adults, irrespective of whether the issue is the right to be free from bodily restraints or the right to choose the direction of their lives. As noted previously, children clearly have only a limited liberty right *vis-a-vis* the State, having been limited, for instance, in the things which they may read[64], and the things which they may do[65]. It is settled, as this Court held in *Prince v. Massachusetts*, 321 U.S. 158, 170 (1944), that "the power of the state to control the conduct of children reaches beyond the scope of its authority over adults. . . ."

Importantly, not only is a child subject to different restrictions by the State, but he is also subject to restrictions imposed by his parents, as discussed in *Argument I*.

As a result, one child may at his parents' discretion go to an "open school" with almost no restrictions on his physical or mental development. Another child may be forced to attend a military school, where from ages six

[64] *Ginsberg v. New York*, 390 U.S. 629 (1968).
[65] *Prince v. Massachusetts*, 321 U.S. 158 (1944).

to eighteen the child is continuously subjected to "locked doors and windows, regimented routine and institutional hours."[66] Similarly, some children have their own rooms at home, while others are forced to share a room with one, two, or more persons. The list of illustrations is limited only by a parent's imagination, his philosophy of child rearing, his resources, and as noted, certain State laws.

The point, of course, is that there is no "baseline" which may be applied to measure a child's right to be "free" of restrictions, because, leaving aside child abuse, there is no generally accepted concept of what restrictions may be placed on a child. Without a point from which to measure the deprivation imposed by a restriction, the doctrine of "less drastic means" becomes useless and meaningless.

Any attempt to apply this doctrine demonstrates the truth of the Appellants' contention. Who would argue that J.L. and J.R., at the ages of six and seven, should have had the freedom to do as they pleased. These children, like most children, undoubtedly did what their parents or guardians directed them to do. They got up in the morning when they were told, they ate when they were told, they went to bed when they were told. To try to articulate a standard or norm out of this, which can be used as a basis for the application of the "less drastic means" doctrine, is to ignore reality.

Even if the "less drastic means" theory could be articulated in such a manner as would allow it to be applied to children, the facts contained in the record would not support such an application in the present case.

[66] Opinion of the District Court, Juris. St. 48a.

The district court found (based on information provided by the Appellants[67]) that some of the children in the class could be treated in other settings which were characterized as "most appropriate." The district court inferred from this that each different treatment setting represented a less drastic setting for the child than the preceding setting. However, there is no substantial evidence to establish the validity of the district court's conclusion that "most appropriate" is synonymous with the least amount of bodily restraint on the child. In fact, both the evidence and common sense dictate to the contrary.

Certainly the district court assumed, and this is an assumption perhaps shared by others, that institutions severely restrain a child's freedom; that the child can only venture forth when accompanied by an attendant; and that the child is routinely kept behind locked doors. However, the testimony before the district court indicated that institutions place only those physical restraints on a child which are dictated by the child's condition. As Superintendent Mazur noted about the children:

> "They may go to the stores and take bike rides on the campus. . . . They may sign out for an unescorted walk, have weekends or longer than twenty-four hour passes, may go to the snack bar unattended, and so on." (A. 484).

Similarly, when questioned about the restrictions imposed upon children in the hospital setting, Dr. Wayne Hodges, one of the Appellees' witnesses, testified:

> "They do have activity therapy and they are given an opportunity to go out on a daily basis. This is determined partly by the particular problem of the individual and the amount of ward help available for

[67] Opinion of the District Court, Juris. St. 21a.

> monitoring the children. But at least as it is set up all of them have an opportunity to go out if their behavior and the circumstances let them go out." (A. 37).

In short, close supervision and physical confinement, if any, are predicated on the child's individual condition, not on the district court's characterization of the treatment setting as "drastic" or "less drastic."

The record simply does not support a conclusion that any of the treatment settings typically involve more or less bodily restraint than any other. Obviously the restraints in any type of treatment setting cannot be characterized by generalizations, since the restrictions in each instance will depend chiefly on the nature and attitudes of the persons having control over the child, whether it be a foster parent or a house mother in a group home or hospital. To say that different treatment settings vary absolutely in the magnitude of the restrictions imposed upon the children is to ignore both the facts in the record and human nature.

One additional issue should be considered in evaluating the validity of the district court's order directing that the children be placed in a "less drastic" setting. In addition to the traditional freedom from bodily restraint recognized by the courts, the district court also found that children have a more general constitutional right to liberty, which includes the freedom to "be a normal child in a normal household cared for by normal parents."

The Appellants do not quarrel with the ideal of every child being normal, and living in a normal household with normal parents, so long as this does not mean that the State is to establish and enforce a single correct lifestyle. Unfortunately, the truth of the matter is that not every child is, or can be, normal, however that elusive term

might be defined, nor can every household and parent be normal. The district court's goal is perhaps socially desireable, but it is not a constitutional right recognized by this Court. *Cf. Maher v. Roe*, _____U.S._____, 45 U.S.L.W. 4787 (No. 75-1440, decided June 20, 1977). Furthermore, a right to be "normal" should not be recognized if, as here, its practical effect will be to deny a child needed treatment.

Therefore, to the extent that the district court attempted to apply the "less drastic means" doctrine based on the concept that the child's "liberty" was being affected, either by the imposition of unwarranted bodily restraints or upon some notion that a child has a constitutional right to be normal, such decision is erroneous and must be reversed.

B. Requiring that mentally ill children be treated only in "most appropriate" treatment settings will deny care to mentally ill children.

In applying the "less drastic means" doctrine to the providing of treatment for mentally ill children, the district court interchanged the concept embodied in the "less drastic means" doctrine with the district court's own theory that children must be treated in the "most appropriate" treatment setting. In Part A, the Appellants demonstrated that the two concepts are not interchangeable, and that the "less drastic means" doctrine has no applicability in the present case.

This leaves the issue of whether the district court's creation, the requirement that mentally ill children be treated in the "most appropriate" treatment setting, has any viability. It is the Appellants' contention that it does not, for it has no support in law and is wholly illogical in practice.

In response to requests for care from persons who are mentally ill, but not ill to the degree which would require involuntary commitment to a State mental health facility, the State of Georgia maintains essentially one type of facility which is available to all who meet certain minimum qualifications. As a result, some people, young and old, may be receiving care in settings which are not "most appropriate." However, it does not follow that by only providing what, in some circumstances, constitutes minimal care, that the State has unconstitutionally deprived the persons using these facilities of their rights. *See Dandridge v. Williams*, 397 U.S. 471 (1970).

In *San Antonio School District v. Rodriguez*, 411 U.S. 1 (1973), this Court had before it the issue of whether it was constitutionally permissible for a state to create a school system and finance it in such a manner that one school district provided only a minimal level of education while other districts provided facilities and personnel which far exceeded this minimal level. The viability of the district court's decision here, finding a supposed right to be treated in nothing other than a "most appropriate" facility, can be illuminated by a consideration of the facts and decision in *Rodriguez*.

In Texas every child was compelled, by a compulsory school law, to attend school. The child was subjected to control by teachers who told him what to do and when to do it, and who could under the Constitution inflict corporal punishment for disobedience. *See Ingraham v. Wright, supra.*

No doubt any number of these children would be characterized as "involuntary" scholars, using the district court's analysis in the present case. Under the district court's holding here, those children would be entitled to

nothing less than the "most appropriate" school setting. We submit that such a holding would be irreconcilable with the actual decision of this Court in *Rodriguez*, and thus the district court's analysis is fatally flawed.

The district court's decision is not legally sound; neither is it logical. Just as the children involved in this Court's decision in *Rodriguez* are not constitutionally entitled to the best, neither are the children involved in this case; however, that is precisely what the district court has mandated, directing that:

> "The defendants shall further spend such money of the State of Georgia as is reasonably necessary to provide such non-hospital facilities and personnel and to place these children in such non-hospital facilities."[68]

The district court made it clear that if the State is to continue providing services to children, it will be required to shape for each child, the treatment setting which is "most appropriate" for that child, irrespective of the cost or the current availability of that particular setting.

The result is that some mentally ill children would necessarily be denied treatment. To illustrate, as this Court noted in *OFFER*, *supra*, 97 S.Ct. at 2106, n. 40, sometimes "[q]ualified foster parents are hard to find," and even when money is available, few people volunteer to care for emotionally disturbed children[69]. Thus, if a child needs treatment, and if the responsible person, whether it is the hospital personnel or even a court, determines that the "most appropriate" treatment setting

[68] Opinion of the District Court, Juris. St. 54a.

[69] In the eight-county area surrounding Baldwin County, where J.L. was located, funds were allocated for a specialized foster home for over a year, but the State could not find a couple to fill the position. Testimony of Ann Etheridge, (A. 681).

is a specialized foster home, then no other place will do. It makes no difference that the treatment could be rendered in a hospital or a group home; that would not be "most appropriate."

This result should be abhorrent to everyone who can perceive what it portends. It means that two persons, one a child, and the other an adult, both suffering from the same mental illness, cannot get the same treatment. The adult, because of his majority, can accept the treatment setting which the State provides, even though it may not be the "most appropriate" setting because he is legally able to assume the risks, if any, attendant upon that decision. On the other hand, the district court has decreed that parents, physicians, and even courts are incapable of correctly deciding that these risks may be assumed by a child.

The result of applying the concept created by the district court is that mentally ill children will be the victims of discrimination which they do not deserve and cannot avoid. Such a result—that some mentally ill child must be denied treatment—will be as tragic in practice as it is unsupportable in theory.

CONCLUSION

For the foregoing reasons, the Appellants respectfully urge this Court to reverse the decision of the lower court.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I, R. Douglas Lackey, one of the attorneys for the Appellants herein, and a member of the Bar of the Supreme Court of the United States, hereby certify that I have this day served opposing counsel in this action with three copies of the foregoing Brief of Appellants, by depositing three copies of the same in the United States mail, with first class postage prepaid, addressed as follows:

Joseph J. Levin, Jr.
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This ____ day of August, 1977.

R. DOUGLAS LACKEY
Assistant Attorney General

APPENDIX "A"

Chapter 24A-41

Mentally Ill and Mentally Retarded Children

24A-4101. Purpose. The purpose of this Chapter is to provide an alternative method of securing hospitalization for mentally ill and mentally retarded children. The General Assembly of Georgia herewith specifically recognizes and states that the method of seeking hospitalization for mentally ill and mentally retarded children set forth in this Chapter is cumulative and is not to be used in lieu of present methods of providing treatment for mentally ill children either under this Title or under Code Chapter 88-4, 88-5 and 88-25, but it is only to be used in the event that these other methods are not available. The General Assembly specifically recognizes that the Juvenile Court may make disposition of mentally ill and mentally retarded children utilizing Code section 24A-2601 in appropriate cases, and recognizes the primary jurisdiction of the Juvenile Courts over the commitment of mentally ill and mentally retarded children who meet the standards and criteria found in Code Chapters 88-4, 88-5 and 88-25.

24A-4102. Emergency Receiving Facilities. Any person or other entity having legal custody, or physical custody if the legal custodian cannot be contacted after a diligent search, of any child under 17 years of age who believes that that child may be suffering from mental retardation or mental illness, and is in need of immediate medical attention, may cause the child to be taken to and examined at any emergency receiving facility in this State as defined in Code Title 88. If the physician in responsible charge at the emergency receiving facility believes that the child is mentally ill or mentally retarded, is in need of immediate medical attention, and is in need

of hospitalization, the child may be admitted to the emergency receiving facility, but not otherwise.

24A-4103. Notice. Whenever any child is brought to any emergency receiving facility pursuant to this Chapter, notice shall be given immediately to the child's parents, guardian or legal custodian in the most expeditious manner possible or if there be none, then, irrespective of whether the child is alleged to be mentally ill or mentally retarded, the procedures contained in Code section 88-502.15 shall be used to appoint representatives or a guardian ad litem for the child.

24A-4104. Petition. If any child is admitted to an emergency receiving facility, the person seeking the admission shall, within 24 hours after the admission of the child, excluding Saturdays, Sundays and holidays, cause a petition to be filed with the juvenile court in the county of residence of the child. If the person filing the petition does not know and is unable with reasonable diligence to determine the actual county of residence of the child, the county in which the emergency receiving facility is located shall be deemed to be the county of the child's residence for the purpose of this Chapter. The petition shall be verified and may be on information and belief. It shall set forth plainly:

(a) The facts which bring the child within the jurisdiction of the court.

(b) The facts which led the person filing the petition to believe that the child is either mentally ill or mentally retarded, and in need of hospitalization.

(c) The petition shall have attached thereto a statement of a physician stating that he has examined the child within the past 5 days and setting forth the nature

and results of the examination which led the physician to believe that the child is mentally ill or mentally retarded, in need of immediate medical attention, and in need of hospitalization. Provided, however, a physician's certificate, containing the same information referenced above, obtained at the emergency receiving facility described hereinbefore will meet this requirement.

(d) The names and residence addresses, if known to the petitioner, of the parents, guardian or custodian of the child and of the child's spouse, if any. If none of the child's parents, guardian or custodian resides or can be found within the State or if their respective places of residence addresses are unknown, the name and residence address of any known adult relative residing within the county, or if there be none, the name and residence address of the known adult relative residing nearest to the location of the court; or if there be none, the representatives as defined in Code section 24A-4103.

(e) The place where the child is being kept at the time of the filing of the petition.

24A-4105. Filing of Petition. If the person who sought admission to the emergency receiving facility for the child does not file the petition required by Code section 24A-4105, within 24 hours, the superintendent of the facility in which the child is located shall do so. The filing of the petition by the superintendent of the facility shall occur within 48 hours of the child's admission to the emergency receiving facility excluding Saturdays, Sundays and holidays. The juvenile court in which the petition is filed shall, within 3 days of the filing of the petition, excluding Saturdays, Sundays and holidays, cause a hearing to be held to determine whether there is probable cause to believe that the child is mentally ill or mentally retarded and in need

of hospitalization. This hearing and the hearing required by Code section 24A-4107 may be held concurrently so long as the hearing is held within 3 days of the filing of the petition.

24A-4106. Hospitalization of the Child. During the time after the child is admitted to an emergency receiving facility, the child may be kept at any approved facility, or institution as that term is defined in Code Chapters 88-4, 88-5, or 88-25; provided that notice is given to the parents, guardian, legal custodian, or representative of the child, as to the child's location.

24A-4107. Summons. (a) After the petition has been filed the court shall fix a time for a hearing thereon which shall be not later than 10 days after the filing of the petition. The court shall direct the issuance of a summons to the parents, guardian or other custodian, a guardian ad litem, or any other persons as appears to the court to be proper or necessary parties to the proceedings, requiring them to appear before the court at the time fixed for the hearing. The summons shall also be directed to the child if the child is fourteen or more years of age. A copy of the petition shall accompany the summons unless the summons is served by publication in which case the published summons shall indicate the general nature of the allegations and where a copy of the petition can be obtained. The summons shall be served in accordance with Code section 24A-1702, but if service must be obtained by certified mail or by publication the ten-day period in which the hearing is to be held shall be tolled pending the service of the summons.

24A-4108. Conduct of Hearings. All hearings shall be conducted in the same manner as set forth in Code Chapter 24A-18.

24A-4109. Rights. All persons shall have the same rights in any proceeding under this Chapter as they would have in a deprivation proceeding conducted under the provisions of Code Title 24A, specifically including the provisions of Code section 24A-2101. Further, the child shall have a right to seek a writ of habeas corpus and to apply to the juvenile court for a protective order if necessary.

24A-4110. Findings and Disposition. (a) After hearing the evidence on any petition alleging that a child is mentally ill or mentally retarded and in need of hospitalization, the court shall make findings as to whether the child is in fact mentally ill or mentally retarded and whether the child is in fact in need of hospitalization. If the court finds that the child is not mentally ill or mentally retarded, or that, if mentally ill or mentally retarded, the child is not in need of hospitalization, the petition shall be dismissed and the child shall be discharged from the facility. It is expressly provided that the dismissal of a petition under this Chapter shall not bar any proceeding initiated under any other section of this Code Title.

(b) If the court finds that the child is in fact mentally ill or mentally retarded and is in need of hospitalization, in the absence of an agreement between the concerned parties, which agreement is approved by the court, the court shall immediately commit the child to the Department of Human Resources for hospitalization at a facility or institution to be determined by the Department of Human Resources. The child shall remain under the jurisdiction of the Department of Human Resources only so long as the child continues to need to be hospitalized or until the order of the juvenile court expires, whichever is earlier. The order of the juvenile court shall expire 6

months from the date it was entered, but may be, after hearing, extended for an additional 6 months and as many times thereafter as may be necessary.

24A-4111. Hospitalization. To find that a child is in need of hospitalization, it must be determined that the child is mentally ill or mentally retarded and that the child's illness or condition can most appropriately be treated in a hospital setting. Any child who is mentally ill or mentally retarded but who can be treated most appropriately in an available less restrictive setting may not be hospitalized under this Chapter.

24A-4112. Children in the Custody of the Department of Human Resources. In the event that it is determined, by a court or otherwise, that any child presently or hereinafter hospitalized in any facility in the State of Georgia has been placed in such facility through a procedure or pursuant to a law which is determined to be invalid, the person or persons in responsible charge of the facility in which the child is hospitalized shall herewith be authorized to file a petition in the juvenile court of the child's residence alleging that the child is mentally ill or mentally retarded and in need of hospitalization in the same manner as though the child had beer. brought to the facility as provided in Code section 24A-4102. After such petition is filed, the issue of whether the child is to remain hospitalized shall be determined as provided in this Chapter.